

FIG. 1  
(PRIOR ART)

09927972.022802

208220.2/5/2660

PHYSICAL EXAM - Skin Findings

Yes No

☒ ☐ cyanosis

☐ ☐ cool skin

☐ ☒ skin rash

☐ ☐ pallor

☐ ☐ diaphoresis

☐ ☐ poor skin turgor

OK

Cancel

FIG. 2

User

1	2	3
4	5	6
7	8	9
◀	0	C

208220" 2662660

2/36

FIG. 3

User rlangdon									
File Edit View Setup									
My Patients									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
7	63y	F	car drove off cliff	Grace	11:26	04/12/01	17 MVA	langdon	
12	18m	M	bean in nose	Ricky	15:44	04/12/01	28 Nose	langdon	

Patients Waiting									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
			NEW COMPLAINT	NEW PATIENT					
	49y	F	horse stepped on foot	Ethyl	16:37	04/12/01			
	118y	F	headache	Mary	16:26	04/12/01			
	56y	M	car crash	Ernie	16:18	04/12/01			
	29y	M	abdominal pain	Jack	15:26	04/12/01			
	37y	M	chest pain	Desi	15:04	04/12/01			

T-Chart	Grace	My Home	Annotations	Notes	Clinical	History	Exam	Course	Dx/Di	Viewing	Report	Discharge	Prescription	Excuse	Printing	Clinical	Discharge	Closure	Print
---------	-------	---------	-------------	-------	----------	---------	------	--------	-------	---------	--------	-----------	--------------	--------	----------	----------	-----------	---------	-------

Title:METHOD FOR ENTERING,  
RECORDING, DISTRIBUTING AND  
REPORTING DATA  
Inventor(s): Woodrow W. Gandy et al  
U.S. Serial # 09/927,972

**3/36**

**FIG. 4**

User rlangdon									
File		Edit		View		Setup		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
My Patients									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
7	63y	F	car drove off cliff	Grace	11:26	04/12/01	17	MVA	langdon
12	18m	M	bean in nose	Ricky	15:44	04/12/01	28	Nose	langdon

Patients Waiting									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
			NEW COMPLAINT	NEW PATIENT					
	49y	F	horse stepped on foot	Ethyl	16:37	04/12/01			
	118y	F	headache	Mary	16:26	04/12/01			
	56y	M	car crash	Ernie	16:18	04/12/01			
	37y	M	chest pain	Desi	15:04	04/12/01			
	29y	M	abdominal pain	Jack	04/12/01	3 2			

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FIG. 5

User rlangdon									
File Edit View Setup [Icons]									
My Patients									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
29y	M		abdominal pain	Jack	15:26 04/12/01		langdon		
7	63y	F	car drove off cliff	Grace	11:26 04/12/01	17 MVA	langdon		
12	18m	M	bean in nose	Ricky	15:44 04/12/01	28 Nose	langdon		
Patients Waiting									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
			NEW COMPLAINT	NEW PATIENT					
49y	F		horse stepped on foot	Ethyl	16:37 04/12/01				
118y	F		headache	Mary	16:26 04/12/01				
56y	M		car crash	Ernie	16:18 04/12/01				
37y	M		chest pain	Desi	15:04 04/12/01				

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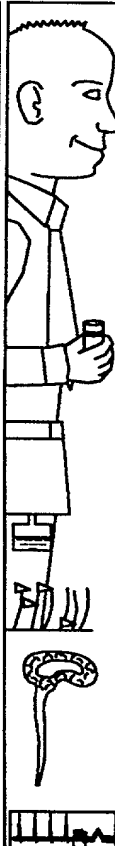
5/36

FIG. 6

User rlangdon										<input type="button" value="File"/> <input type="button" value="Edit"/> <input type="button" value="View"/> <input type="button" value="Setup"/> <input type="button" value="Print"/> <input type="button" value="Help"/>	
My Patients											
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician				
7	63y	F	car drove off cliff	Grace	11:26 04/12/01	17 MVA	langdon				
8	29y	M	abdominal pain	Jack	15:26 04/12/01		langdon				
12	18m	M	bean in nose	Ricky	15:44 04/12/01	28 Nose	langdon				
Patients Waiting											
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician				
			NEW COMPLAINT	NEW PATIENT							
49y	F		horse stepped on foot	Ethyl	16:37 04/12/01						
118y	F		headache	Mary	16:26 04/12/01						
56y	M		car crash	Ernie	16:18 04/12/01						
37y	M		chest pain	Desi	15:04 04/12/01						
<input type="button" value="T-Chart"/> <input type="button" value="Jack"/> <input type="button" value="Home"/> <input type="button" value="Annotations"/> <input type="button" value="Notes"/> <input type="button" value="Clinical"/> <input type="button" value="History"/> <input type="button" value="Exam"/> <input type="button" value="Course"/> <input type="button" value="Dx/Di"/> <input type="button" value="Viewing"/> <input type="button" value="Report"/> <input type="button" value="Discharge"/> <input type="button" value="Prescription"/> <input type="button" value="Excuse"/> <input type="button" value="Printing"/> <input type="button" value="Clinical"/> <input type="button" value="Discharge"/> <input type="button" value="Closure"/> <input type="button" value="Help"/>											

FIG. 7

T-Chart Template Selector
✕

	Trauma	Medicine	
	<ol style="list-style-type: none"> <li>1 Head Injury</li> <li>2 Eye Problems</li> <li>3 head Injury, Facial</li> <li>4 Neck/Back Pain or Injury</li> <li>5 Shoulder Injury</li> <li>6 Upper Extremity Injury</li> <li>7 Trunk Injury</li> <li>8 Low Back Pain or Injury</li> <li>9 Hand/Wrist Injury</li> <li>10 Hip Injury</li> <li>11 Lower Extremity Injury</li> <li>12 Ankle/Foot Injury</li> <li>13 Plantar Puncture Wound</li> <li>14 Pediatric Illness</li> <li>15 Asthma-pediatric</li> <li>16 Pediatric trauma</li> <li>17 MVA</li> <li>17a MCA Bike/Pedestrian</li> <li>18 Multiple trauma</li> <li>19 Fall</li> <li>20 Assault</li> <li>21 Animal Bite</li> <li>22 Major Burn/Smoke Inhalation</li> <li>23 Recheck/Suture Removal</li> <li>24 General</li> </ol>	<ol style="list-style-type: none"> <li>26 Headache</li> <li>27 Ear Complaints</li> <li>28 Nose</li> <li>29 Throat or Dental Pain</li> <li>30 Cough</li> <li>31 Wheezing/Asthma</li> <li>32 Dyspnea</li> <li>33 Chest Pain</li> <li>34 Palpitations</li> <li>35 Upper Extremity Pain</li> <li>36 Abdominal Pain</li> <li>37 Vomiting/Diarrhea</li> <li>38 GI bleeding/Rectal Pain</li> <li>39 Female GU</li> <li>40 OB Problems</li> <li>41 Male GU</li> <li>42 Lower Extremity Pain</li> <li>43 Skin Rash/Abscess</li> <li>44 Allergy</li> <li>45 Changed Mental Status</li> <li>46 Focal Neuro Deficit</li> <li>47 Dizzy</li> <li>48 Syncope</li> <li>49 Seizure</li> <li>50 CPR</li> <li>51 Critical Care</li> <li>52 Overdose</li> <li>53 Psych</li> </ol>	

Ok
Cancel

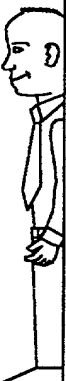

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FIG. 8

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T-Chart Template Selector

Trauma	Medicine
 1 Head Injury 2 Eye Problems 3 head Injury, Facial 4 Neck/Back Pain or Injury 5 Shoulder Injury 6 Upper Extremity Injury 7 Trunk Injury 8 Low Back Pain or Injury 9 Hand/Wrist Injury 10 Hip Injury 11 Lower Extremity Injury 12 Ankle/Foot Injury 13 Plantar Puncture Wound 14 Pediatric Illness 15 Asthma-pediatric 16 Pediatric trauma 17 MVA 17a MCA Bike/Pedestrian 18 Multiple trauma 19 Fall 20 Assault 21 Animal Bite 22 Major Burn/Smoke Inhalation 23 Recheck/Suture Removal 24 General	 26 Headache 27 Ear Complaints 28 Nose 29 Throat or Dental Pain 30 Cough 31 Wheezing/Asthma 32 Dyspnea 33 Chest Pain 34 Palpitations 35 Upper Extremity Pain 36 Abdominal Pain 37 Vomiting/Diarrhea 38 GI bleeding/Rectal Pain 39 Female GU 40 OB Problems 41 Male GU 42 Lower Extremity Pain 43 Skin Rash/Abscess 44 Allergy 45 Changed Mental Status 46 Focal Neuro Deficit 47 Dizzy 48 Syncope 49 Seizure 50 CPR 51 Critical Care 52 Overdose 53 Psych

Ok Cancel

FIG. 9A

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle EMS		context: _____	
Home		historian: patient EMS family		limited by: _____	
Annotations		OHPI			
L S		chief complaint: abdominal pain _____		flank pain _____	
Notes		started: just PTA today last night yesterday _____			
Clinical		still present _____		gone _____	timing: _____
History		location: R chest, central- L chest			
Exam		epig RUQ upper LUQ			
Course		generalized			
DrD1		RLQ ILQ			
Viewing		R flank			
Report		R back			
Discharge		L back			
Prescription		radiating to: _____		additional pain _____	
Excuse		associated symptoms:			
Printing		nausea _____		vomiting _____	
Clinical		loss of appetite _____		diarrhea _____	
Discharge		severity of pain: _____			
		modifying factors: _____			

GI		vomiting blood _____		CONSTITUTIONAL	
		black stools _____		fever _____	
		bloody stools _____		Neuro & EENT	
URINARY		difficulty w/urination _____		headache _____	
		pain w/urination _____		sore throat _____	
		frequency _____		blurred vision _____	
Female		pregnant _____		CVS & Pulmonary	
LNMP		missed periods _____		chest pain _____	
		abdominal bleeding _____		difficulty breathing _____	
		all systems neg. except as marked		cough _____	
				MS & Skin	
				joint pain _____	
				skin rash _____	

OPAST Hx		negative _____		see nurses notes _____	
		peptic ulcer _____		heart diz _____	
		gall stones _____		lung diz _____	
		bowel obstruction _____		renal dz _____	
		kidney stones _____		HTN _____	
				diabetes _____	
				hyperlipidemia _____	
				previous surgery _____	
				abdominal surgery _____	

A



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9/36

FIG. 9B

<div style="border: 1px solid black; padding: 2px;">Closure</div> <div style="border: 1px solid black; padding: 2px;"> <input type="checkbox"/> <input type="checkbox"/> </div>		similar symptoms previously: once twice sev. times many times - occasionally frequently milder as bad worse varying 0		0 MEDS _none _see nurses notes 0 ALLERGIES _NKDA _see nurses notes 0 SOCIAL Hx smoker _ ETOH _ drugs _ residence/travel: 0 FAMILY Hx gall bladder heart dz hx of: 0	
---	--	--	--	---	--

FIG. 10

T-Chart		Abdominal Pain		time: room:	
Jack		arrived: pvt vehicle EMS		context:	
<div style="border: 1px solid black; padding: 2px;"> <input type="checkbox"/> Home         </div>		historian: patient EMS family limited by:			
<div style="border: 1px solid black; padding: 2px;"> <input type="checkbox"/> Annotations         </div>		chief complaint: abdominal pain		flank pain	
<div style="border: 1px solid black; padding: 2px;"> <input type="checkbox"/> 2         </div>		started: just PTA today last night yesterday			
<div style="border: 1px solid black; padding: 2px;"> <input type="checkbox"/> Notes         </div>		still present gone timing:			
<div style="border: 1px solid black; padding: 2px;"> <input type="checkbox"/> Clinical         </div>		quality "pain" sharp		location: R chest - central - L chest / epig	
<div style="border: 1px solid black; padding: 2px;"> <input type="checkbox"/> History         </div>					

OROS	
GI	CONSTITUTIONAL
_vomiting blood	_fever _chills
_black stools	Neuro & EENT
_bloody stools	_headache
URINARY	_sore throat
_difficulty w/urination	_blurred vision
_pain w/urination	CVS & Pulmonary
_frequency	_chest pain
Female	_difficulty breathing
LNMP	_cough

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FIG. 11

<b>T-Chart</b>	<b>Abdominal Pain</b>	<b>time:</b> _____ <b>room:</b> _____
<b>Jack</b>	<b>arrived:</b> pvt vehicle EMS _____ <b>context:</b> _____	
<b>Home</b>	<b>historian:</b> patient EMS family _____ <b>limited by:</b> _____	
<b>Annotations</b>	<b>OHPI</b>	
<b>Notes</b>	<b>chief complaint:</b> (abdominal pain) _____ <b>flank pain</b> _____	
<b>Clinical</b>	<b>started:</b> just PTA today <b>last night</b> yesterday _____	
<b>History</b>	<b>still present</b> _____ <b>gone</b> _____ <b>timing:</b> _____	
<b>Exam</b>	<b>quality:</b> _____ <b>location:</b> R chest, central-L chest, epig, RUQ upper LUQ, generalized, L flank	
<b>Course</b>	<b>sharp</b> _____ <b>stabbing</b> _____ <b>cramping</b> _____ <b>burning</b> _____ <b>dull</b> _____ <b>migrating</b> _____	
<b>Viewing</b>	<b>well localized</b> _____ <b>diffuse</b> _____	
<b>Report</b>	<b>radiating to:</b> _____ <b>additional pain</b> _____	
<b>Discharge</b>	<b>associated symptoms:</b> _____	
<b>Prescription</b>	<b>nausea</b> _____ <b>vomiting</b> _____	
<b>Excuse</b>	<b>loss of appetite</b> _____ <b>diarrhea</b> _____	
<b>Printing</b>	<b>severity of pain:</b> _____	
<b>Clinical</b>	<b>modifying factors:</b> _____	
<b>Discharge</b>		

<b>GI</b>	<b>CONSTITUTIONAL</b>
vomiting blood	fever
black stools	chills
bloody stools	Neuro & EENT
difficulty w/urination	headache
pain w/urination	sore throat
frequency	blurred vision
Female	CVS & Pulmonary
LNMP	chest pain
missed periods	difficulty breathing
abdominal bleeding	cough
all systems neg. except as marked	MS & Skin
	joint pain
	back pain
	skin rash

<b>OPAST Hx</b>	
negative	see nurses notes
peptic ulcer	
gall stones	
bowel obstruction	
kidney stones	
heart diz	neuro diz
lung diz	GI diz
renal dz	other dz
HTN	diabetes
hyperlipidemia	
previous surgery	
abdominal surgery	

208220" 24622660

FIG. 12

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle	EMS	context: _____	
		historian: patient	EMS family	limited by: _____	
OHPI					
Annotations		chief complaint: <u>abdominal pain</u> _____ flank pain _____			
L S		started: just PTA today last night yesterday _____			
Notes		still present _____ gone _____ timing: _____			
Clinical		location: R chest - central - L chest			
History		epig RUQ upper LUQ L flank			
Exam		generalized R flank LUQ L back			
Course		RLQ R pelvis pelvis L pelvis			
DrDI		suprapub ^ additional pain			
Viewing		R back			
Report		radiating to: _____			
Discharge		associated symptoms: _____			
Prescription		nausea _____ vomiting _____			
Excuse		loss of appetite _____ diarrhea _____			
Printing		severity of pain: _____			
Clinical		modifying factors: _____			
Discharge					

OROS		OPAST Hx	
GI	vomiting blood _____ black stools _____ bloody stools _____ URINARY difficulty w/urination _____ pain w/urination _____ frequency _____ Female _____ pregnant _____ LNMP missed periods _____ irreg _____ abdominal bleeding _____ all systems neg. except as marked _____	negative _____ see nurses notes _____ peptic ulcer _____ gall stones _____ bowel obstruction _____ kidney stones _____	heart diz _____ neuro diz _____ lung diz _____ GI diz _____ renal dz _____ other dz _____ HTN _____ diabetes _____ hyperlipidemia _____ previous surgery _____ abdominal surgery _____
CONSTITUTIONAL			
fever _____ chills _____			
Neuro & EENT			
headache _____			
sore throat _____			
blurred vision _____			
CVS & Pulmonary			
chest pain _____			
difficulty breathing _____			
cough _____			
MS & Skin			
joint pain _____ back pain _____			
skin rash _____			

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FIG. 13

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle EMS		context: _____	
		historian: patient EMS family		limited by: _____	
OHPI					
Annotations		chief complaint: <u>abdominal pain</u> _____ flank pain _____			
L S		started: just PTA today last night yesterday _____			
Notes		still present _____ gone _____ timing: _____			
Clinical		location: R chest, central-L chest			
History		<div style="display: flex; justify-content: space-around;"> <div> <p>R flank</p> <p>epig</p> <p>RUQ upper LUQ</p> <p>generalized</p> <p>o</p> <p>RLQ</p> <p>ILQ</p> <p>R pelvis pelvis L pelvis</p> <p>suprapub</p> </div> <div> <p>L flank</p> <p>L back</p> </div> </div>			
Exam		<p>quality _____</p> <p>"pain" _____</p> <p>sharp _____</p> <p>stabbing _____</p> <p>cramping _____</p> <p>burning _____</p> <p>dull _____</p> <p>migrating _____</p> <p>... _____</p> <p>well localized _____</p> <p>diffuse _____</p>			
Course		radiating to: _____ additional pain _____			
DxDI		associated symptoms: _____			
Viewing		<p>nausea _____ vomiting _____</p> <p>loss of appetite _____</p> <p>diarrhea _____</p>			
Report		severity of pain: _____			
Discharge		modifying factors: _____			
Prescription					
Excuse					
Printing					
Clinical					
Discharge					

OROS	
GI	<u>CONSTITUTIONAL</u> _____ fever _____ chills _____ _____ Neuro & EENT _____ headache _____ _____ sore throat _____ _____ blurred vision _____ <u>URINARY</u> _____ difficulty w/urination _____ _____ pain w/urination _____ _____ frequency _____ Female _____ pregnant _____ <u>LNMP</u> _____ missed periods _____ irreg _____ _____ abdominal bleeding _____ _____ all systems neg. except as marked _____
OPAST Hx	_____ negative _____ see nurses notes _____ _____ peptic ulcer _____ _____ gall stones _____ _____ bowel obstruction _____ _____ kidney stones _____ _____ heart diz _____ _____ lung diz _____ _____ renal dz _____ _____ HTN _____ _____ hyperlipidemia _____ _____ previous surgery _____ _____ abdominal surgery _____

13/36

FIG. 14

T-Chart		Abdominal Pain		time: _____	room: _____
Jack	arrived: pvt vehicle EMS	EMS	context: _____		
Home	historian: patient EMS family	limited by: _____			
Annotations	OHPI				
Notes	chief complaint: (abdominal pain) _____ flank pain _____				
	started: just PTA today last night yesterday _____				
	still present _____ gone _____ timing: _____				
Clinical	<div style="display: flex; justify-content: space-between;"> <div>           quality "pain" sharp stabbing cramping burning dull migrating            ... well localized diffuse         </div> <div>           location: R chest - central - L chest                              epig                              RUQ upper LUQ                              generalized                              L flank                              R flank                              RLQ ILQ                              R pelvis pelvis L pelvis                              suprapub                              L back                              R back         </div> </div>				
History					
Exam					
Course					
Dx/DI					
Viewing					
Report					
Discharge					
Prescription	radiating to: _____ additional pain _____				
Excuse	associated symptoms: _____				
Printing	nausea _____ vomiting _____				
Clinical	loss of appetite _____ diarrhea _____				
Discharge	severity of pain: _____				
	modifying factors: _____				

OROS	
GI	vomiting blood _____ black stools _____ bloody stools _____ URINARY difficulty w/urination _____ pain w/urination _____ frequency _____ Female pregnant _____ LNMP missed periods irreg _____ abdominal bleeding _____ all systems neg. except as marked _____
CONSTITUTIONAL	fever chills _____ Neuro & EENT headache _____ sore throat _____ blurred vision _____ CVS & Pulmonary chest pain _____ difficulty breathing _____ cough _____ MS & Skin joint pain back pain _____ skin rash _____
OPAST Hx	
negative	see nurses notes _____ peptic ulcer _____ gall stones _____ bowel obstruction _____ kidney stones _____
heart diz	neuro diz _____ GI diz _____ renal dz _____ HTN _____ hyperlipidemia _____ previous surgery _____ abdominal surgery _____

208220-2462660

FIG. 15

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle EMS		EMS context: _____	
Home		historian: patient EMS family		family limited by: _____	
Annotations		chief complaint: (abdominal pain)		flank pain _____	
S		started: just PTA today last night yesterday			
Notes		still present _____		gone _____	timing: _____
Clinical		quality: _____		location: _____	
History		sharp _____		R chest -central- L chest	
Exam		stabbing _____		epig _____	
Course		cramping _____		RUQ upper LUQ	
Dx/D1		burning _____		generalized _____	
Viewing		dull _____		R flank _____	
Report		migrating _____		RLQ LLQ	
Discharge		... well localized _____		R pelvis pelvis L pelvis	
Prescription		diffuse _____		suprapub _____	
Excuse		radiating to: _____		R back _____	
Printing		associated symptoms: _____		additional pain _____	
Clinical		nausea _____		vomiting _____	
Discharge		loss of appetite _____		diarrhea _____	
		severity of pain: _____			
		modifying factors: _____			

OROS	
GI	CONSTITUTIONAL
vomiting blood _____	fever _____ chills _____
black stools _____	Neuro & ENT
bloody stools _____	headache _____
URINARY	sore throat _____
difficulty w/urination _____	blurred vision _____
pain w/urination _____	CVS & Pulmonary
frequency _____	chest pain _____
Female _____ pregnant _____	difficulty breathing _____
LNMP _____	cough _____
missed periods _____ irreg _____	MS & Skin
abdominal bleeding _____	joint pain _____ back pain _____
all systems neg. except as marked _____	skin rash _____
OPAST Hx	
negative _____ see nurses notes _____	heart diz _____ neuro diz _____
peptic ulcer _____	lung diz _____ GI diz _____
gall stones _____	renal dz _____ other dz _____
bowel obstruction _____	HTN _____ diabetes _____
kidney stones _____	hyperlipidemia _____
	previous surgery _____
	abdominal surgery _____

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TSYS 25,410

Title:METHOD FOR ENTERING,  
RECORDING, DISTRIBUTING AND  
REPORTING DATA

Inventor(s): Woodrow W. Gandy et al

U.S. Serial # 09/927,972

15/36

FIG. 16

T-Chart
Jack
Home
Annotations
Notes
Clinical
History
Exam
Course
Dx/Di
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure
Print

### Clinical Report

Hospital Name -

Emergency Department

Street Address - 214-555-1212

12-Apr-2001

Patient Name: Jack

### HISTORY OF PRESENT ILLNESS

Chief complaint- ABDOMINAL PAIN. He has had nausea and loss of appetite. No vomiting or diarrhea.

Physician Signature

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FIG. 17

T-Chart	Abdominal Pain	time: _____	room: _____
Jack	arrived: pvt vehicle EMS	EMS context: _____	
GP Home	historian: patient EMS family	limited by: _____	
Annotations	OHPI		
Notes	chief complaint: (abdominal pain) _____ flank pain _____		
Clinical	started: just PTA today last night yesterday _____		
History	still present _____ gone _____ timing: _____		
Exam	<div style="display: flex; justify-content: space-between;"> <div>             quality: "pain" sharp stabbing cramping burning dull migrating              ... well localized diffuse           </div> <div>             location: R chest - central - L chest /              RUQ upper LUQ epig generalized              R flank L flank              RLQ LLQ              R pelvis L pelvis              R back L back           </div> </div>		
Course	radiating to: _____ additional pain _____		
Dx01	associated symptoms: _____		
Viewing	nausea _____ vomiting _____		
Report	loss of appetite _____ diarrhea _____		
Discharge	severity of pain: _____		
Prescription	modifying factors: _____		
Excuse			
Printing			
Clinical			
Discharge			

GI	OROS
vomiting blood _____ black stools _____ bloody stools _____ URINARY difficulty w/urination _____ pain w/urination _____ frequency _____ Female _____ pregnant _____ LNMP missed periods _____ irreg _____ abdominal bleeding _____ all systems neg. except as marked _____	CONSTITUTIONAL fever _____ chills _____ Neuro & EENT headache _____ sore throat _____ blurred vision _____ CVS & Pulmonary chest pain _____ difficulty breathing _____ cough _____ MS & Skin joint pain _____ back pain _____ skin rash _____
OPAST Hx	
negative _____ see nurses notes _____ peptic ulcer _____ gall stones _____ bowel obstruction _____ kidney stones _____	heart diz _____ neuro diz _____ lung diz _____ GI diz _____ renal dz _____ other dz _____ HTN _____ diabetes _____ hyperlipidemia _____ previous surgery _____ abdominal surgery _____



T-Chart	Abdominal Pain	time: _____	room: _____
Jack	arrived: pvt vehicle EMS	context: _____	
Home	historian: patient EMS family	limited by: _____	
Annotations	OHPI		
2	chief complaint: (abdominal pain)	flank pain	
	started: just PTA today last night yesterday		
Notes	still present _____ gone _____	timing: _____	
Clinical	quality: _____ location: R chest - central - L chest		
History	sharp _____ epig _____		
Exam	stabbing _____ RUQ upper LUQ _____		
Course	cramping _____ generalized _____		
Dx/DI	burning _____		
Viewing	dull _____		
Report	migrating _____		
Discharge	... well localized _____		
Prescription	diffuse _____		
Excuse	radiating to: _____ additional pain _____		
Printing	associated symptoms: _____		
Clinical	nausea _____ vomiting _____		
Discharge	loss of appetite _____ diarrhea _____		
	severity of pain: _____		
	modifying factors: _____		

**GI**

vomiting blood

black stools

bloody stools

**URINARY**

difficulty w/urination

pain w/urination

frequency

Female pregnant

LNMP

missed periods

abdominal bleed

all systems neg. e

**OPAST Hx**

negative see nur

peptic ulcer

gall stones

bowel obstruction

kidney stones

**OROS**

GI

CONSTITUTIONAL

fever chills

Neuro & EENT

headache

sore throat

blurred vision

CVS & Pulmonary

chest pain

difficulty breathing

cough

**COUGH**

mild moderate severe

dry / productive

scant moderate copious thick thin

clear yellow green brown white

blood tinged frank blood

cough changed from baseline smoker

sputum changed from baseline

similar to previous symptoms

208220 22622660

FIG. 19

<b>T-Chart</b>	<b>Abdominal Pain</b> time: room: arrived: pvt vehicle EMS context: historian: patient EMS family limited by: OHPI
<b>Jack</b>	
<b>Home</b>	
<b>Annotations</b>	chief complaint: (abdominal pain) flank pain started: just PTA today last night yesterday
<b>Notes</b>	still present gone timing: location: R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Clinical</b>	quality "pain" sharp stabbing cramping burning dull migrating ... well localized diffuse
<b>History</b>	R flank R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Exam</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Course</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Dx/DI</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Viewing</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Report</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Discharge</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Prescription</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Excuse</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Printing</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Clinical</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank
<b>Discharge</b>	R back R chest - central - L chest RUQ upper LUQ epig generalized L flank

<b>OROS</b>	<b>GI</b> vomiting blood black stools bloody stools <b>URINARY</b> difficulty w/urination pain w/urination frequency Female - pregnant LNMP missed periods abdominal bleed all systems neg. e	<b>CONSTITUTIONAL</b> fever -chills Neuro & EENT headache sore throat blurred vision CVS & Pulmonary chest pain difficulty breathing (cough)
<b>OPAST Hx</b>	negative - see nur peptic ulcer gall stones bowel obstruction kidney stones	minutes hours days weeks months years 1 2 3 4 5 - for 6 7 8 9 0 1/2 several many occasionally today since yesterday recently chronically -gone now -still present -improving -worsening
COUGH mild moderate (severe) dry / (productive) scant moderate copious (thick) thin clear yellow (green) brown white (blood tinged) frank blood cough changed from baseline smoker sputum changed from baseline ... similar to previous symptoms		

208220-24622660

FIG. 20

T-Chart	Jack	Home	Annotations	Notes	Clinical	History	Exam	Course	Dx/DI	Viewing	Report	Discharge	Prescription	Excuse	Printing	Clinical	Discharge	Closure	Print
---------	------	------	-------------	-------	----------	---------	------	--------	-------	---------	--------	-----------	--------------	--------	----------	----------	-----------	---------	-------

**Clinical Report**  
Hospital Name -  
Emergency Department  
Street Address - 214-555-1212  
12-Apr-2001

Patient Name: Jack

**HISTORY OF PRESENT ILLNESS**  
Chief complaint- ABDOMINAL PAIN. He has had nausea and loss of appetite. No vomiting or diarrhea.

**REVIEW OF SYSTEMS**  
The patient has had a sever cough productive of thick, green, blood tinged sputum. No frankly bloody sputum.

Physician Signature

2083220 2/6/2000

FIG. 21

<b>T-Chart</b>		<b>Abdominal Pain</b>		<b>time:</b> _____ <b>room:</b> _____	
Jack		arrived: pvt vehicle EMS		context: _____	
historian: patient EMS family		limited by: _____			
<b>Annotations</b>		<b>chief complaint:</b> (abdominal pain)		flank pain	
started: just PTA today last night yesterday					
<b>still present</b>		<b>gone</b>		<b>timing:</b> _____	
<b>quality:</b> "pain" sharp stabbing cramping burning dull migrating ... well localized diffuse		<b>location:</b> R chest - central - L chest / RUQ upper LUQ generalized R flank RLQ LLQ R pelvis L pelvis suprapub R back L flank			
<b>radiating to:</b> _____		<b>additional pain:</b> _____			
<b>associated symptoms:</b> nausea vomiting loss of appetite diarrhea severity of pain: _____ modifying factors: _____					
<b>OPAST Hx</b>		negative see nur peptic ulcer gall stones bowel obstruction kidney stones			
<b>GI</b>		vomiting blood black stools bloody stools URINARY difficulty w/urination pain w/urination frequency pregnant LNMP missed periods abdominal bleed all systems neg. e			
<b>CONSTITUTIONAL</b>		fever chills Neuro & EENT headache sore throat blurred vision CVS & Pulmonary chest pain difficulty breathing (cough)			
<b>minutes (&lt;&lt;)</b>		1 2 3 4 5 - for 6 7 8 9 0 1/2		ago times	
<b>hours</b>		several many occasionally		today since yesterday recently chronically	
<b>days</b>		gone now -still present -improving -worsening			
<b>weeks</b>		COUGH mild moderate severe			
<b>months</b>		dry / (productive) scant moderate copious (thick) thin clear yellow (green) brown white (blood tinged) frank blood cough changed from baseline smoker sputum changed from baseline ... similar to previous symptoms			
<b>years</b>					

FIG. 22

T-Chart	Abdominal Pain	time: _____	room: _____
Jack	arrived: pvt vehicle EMS	context: _____	
193 Home	historian: patient EMS family	limited by: _____	
Annotations	OHPI		
2 S	chief complaint: (abdominal pain) flank pain		
Notes	started: just PTA today last night yesterday		
	still present _____ gone _____	timing: _____	
	quality: R chest - central- L chest		
	"pain" epig		
	sharp RUQ upper LUQ		
	stabbing generalized		
	cramping		
	burning		
	dull		
	migrating		
	... well localized		
	diffuse		
	radiating to: _____	additional pain _____	
	associated symptoms:		
	nausea _____ vomiting _____		
	loss of appetite _____ diarrhea _____		
	severity of pain: _____		
	modifying factors: _____		

GI	CONSTITUTIONAL
vomiting blood	fever
black stools	chills
bloody stools	Neuro & EENT
URINARY	headache
difficulty w/urination	sore throat
pain w/urination	blurred vision
frequency	CVS & Pulmonary
Female	chest pain
LNMP	difficulty breathing
missed periods irreg	cough
abdominal bleeding	severe, productive, thick gr
all systems neg. except as marked	MS & Skin
	joint pain
	back pain
	skin rash

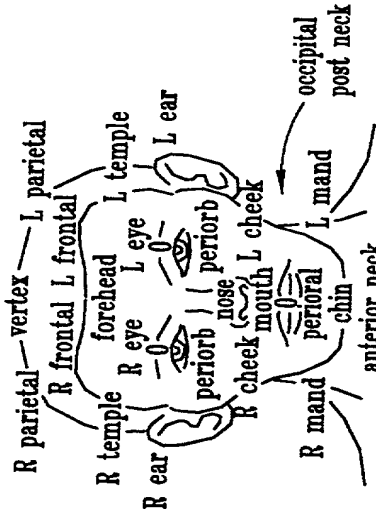
OPAST Hx	negative	see nurses notes	heart diz	neuro diz
	peptic ulcer		lung diz	GI diz
	gall stones		renal dz	other dz
	bowel obstruction		HTN	diabetes
	kidney stones		hyperlipidemia	
			previous surgery	
			abdominal surgery	

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FIG. 23

T-Chart		MVA		time: _____ room: _____	
Jim		arrived: pvt vehicle EMS		context: _____	
Home		historian: patient EMS family		limited by: _____	
Annotations		OHPI			
/ S		chief complaint: MVA			
Notes		location of injuries:			
Clinical		occurred: just PTA today last night yesterday			
History		pain: none _____ mild _____ moderate _____ severe _____			
Exam		assoc: blow head _____ neck pain _____ LOC _____ dazed _____ seizure _____			
Course		mechanism details: 0			
DDI		OROS			
Viewing		numbness weakness _____ trouble breathing _____			
Report		hearing loss _____ nausea vomiting _____			
Discharge		loss of vision _____ bladder dysfunction _____			
Prescription		headache _____ skin laceration _____			
Excuse		chest pain _____ fever recently ill _____			
Printing		depressed _____ all systems neg. except as marked _____			
Clinical		OPAST HISTORY			
Discharge		neg see nurses notes heart dz neuro dz			
Closure		tetanus: UTD >5 >10 unk lung dz GI dz			
D		renal dz other dz			
		HTN diabetes			
		previous surgery			
		0 MEDS none see nurses notes			
		0 ALLERGIES NKDA see nurses notes			
		0 SOCIAL HX smoker _____ ETOH _____ drugs _____			
		residence/travel: _____			

bkbdr c-collar _____ nurses notes rev'd _____ VS rev'd _____	
PHYSICAL EXAM	
_alert _____	
_NAD _____	
HEAD	
_Battle's sign _____ raccoon eyes _____	
_non-tender _____	
_no swelling _____	
R parietal-vertex _____ L parietal	
R frontal L frontal	
forehead L temple	
R temple R eye L eye	
R ear periorb L periorb L ear	
nose periorb L cheek	
R cheek mouth L cheek	
R mand periorb L mand	
chin occipital	
anterior neck post neck	
Add'l Injury 0	
NECK	
_verteb. tenderness _____ painful movement _____	
_decrsd ROM _____ muscle spasm _____	
_non-tender _____	
_painless ROM _____	
EYES	
_pupillary exam: _____	
_ocular injury _____	
_abnml fundiscopic _____	
ENT	
_hematympanum _____	
_malocclusion _____	
_no dental injury _____	
_pharynx nm _____	





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FIG. 25

<b>T-Chart</b>		<b>X-RAYS</b>	
Jim		<input type="checkbox"/> _nml / NAD except as noted	
<input type="checkbox"/> Home		<input type="checkbox"/> _independently visualized by me	
<b>Annotations</b>		<input type="checkbox"/> _discussed with radiologist	
<input type="checkbox"/> L	<input type="checkbox"/> S	<input type="checkbox"/> _interpreted by me contemporaneously	
<b>Notes</b>		<input type="checkbox"/> _interpreted by radiologist	
<b>Clinical</b>		<b>R</b>	
<input type="checkbox"/> History		skull - + orbits - +	
<input type="checkbox"/> Exam		facial - + mandible - +	
<input type="checkbox"/> Course		nasal - + c-spine - +	
<input type="checkbox"/> Dx/Di		<b>L</b>	
<input type="checkbox"/> Viewing		clavicle - + clavicle - +	
<input type="checkbox"/> Report		scapula - + scapula - +	
<input type="checkbox"/> Discharge		shoulder - + shoulder - +	
<input type="checkbox"/> Prescription		humerous - + humerous - +	
<input type="checkbox"/> Excuse		elbow - + elbow - +	
<input type="checkbox"/> Printing		forearm - + forearm - +	
<input type="checkbox"/> Clinical		wrist - + wrist - +	
<input type="checkbox"/> Discharge		hand - + hand - +	
		digit - + digit - +	
		hip - + hip - +	
		femur - + femur - +	
		knee - + knee - +	
		patella - + patella - +	
		tib/fib - + tib/fib - +	
		ankle - + ankle - +	
		foot - + foot - +	
		toe(s) - + toe(s) - +	
		<b>EKG / LABS / SPECIAL STUDIES</b>	
		0 EKG _nml 0 CT Head _NAD 0 CT Abdomen _NAD	
		0 Labs _nml 0 CT Chest _NAD 0 Other studies _neg	
<b>Closure</b>			
<input type="checkbox"/> L			

<b>o PROCEDURE NOTES</b>	
0 Intubation	0 Splint
0 Ventilator Management	0 Wound Repair
0 Central Line	
0 Chest Tube	
<b>PROGRESS</b>	
TIME	-now- stable unstable
	sx's much better better unchg'd
	exam improved unchanged
	[APPLY]
0 trauma course	0 Resp / CVS 0 CPR 0 re-evaluation
consultation / review of records	
D/W Dr.	_old records ordered
D/W Dr. (#2)	_old records reviewed
_tried - can't contact Dr.	_records req - unavailable
_family consultation	_further history sought
hospital admission or transfer	
_admitted	_good condition
_transferred	_stable
_observation status	



FIG. 26

<b>T-Chart</b>	<b>CLINICAL IMPRESSION</b>		<b>PRESCRIPTIONS</b>	
Jim	acute pain _____ MVA MCA bike pedestrian _____ skin fracture laceration _____ skull _____ rib _____ abrasion(s) _____ facial _____ pelvic _____ skin avulsion _____ spine _____ hip _____ foreign body, soft tissue _____ upper ext _____ lower ext _____ soft tissue wrist _____ ankle _____ cervical strain _____ hand _____ foot _____ neck pain _____ other / major injury _____ back pain _____ concussion _____ strain _____ head injury _____ sprain _____ spinal injury _____ contusion _____ hemorrhage _____ dislocation hypotension _____ shoulder _____ shock _____ elbow _____ respiratory failure _____ knee injury _____ chest injury _____ knee injury _____ cardiac arrest _____ hemarthrosis _____ abdominal injury _____ knee instability _____ renal injury _____ _____ dental trauma _____		OTC meds _____ antibiotics Acetaminophen _____ Augmentin _____ Motrin _____ Cephalixin _____ pain / nausea _____ Cipro 10d _____ Darvocet-N _____ muscle _____ Lortab _____ Flexeril _____ Phenergan _____ Robaxin _____ Tylenol w/Cod. _____ Skelaxin _____ _____ Soma _____	
<input type="checkbox"/> Home <input type="checkbox"/> Annotations <input checked="" type="checkbox"/> Notes <input type="checkbox"/> Clinical <input type="checkbox"/> History <input checked="" type="checkbox"/> Exam <input checked="" type="checkbox"/> Course <input type="checkbox"/> Dx/Di <input type="checkbox"/> Viewing <input type="checkbox"/> Report <input type="checkbox"/> Discharge <input type="checkbox"/> Prescription <input type="checkbox"/> Excuse <input type="checkbox"/> Printing <input checked="" type="checkbox"/> Clinical <input checked="" type="checkbox"/> Discharge	more diagnoses _____ 0 Allergy _____ 0 Cardiology _____ 0 Dermatology _____ 0 ENT 0 Eye _____ 0 Environmental _____ 0 Gastrointestinal _____ 0 Infectious Disease _____ 0 Int Medicine, Gen 1 _____ 0 Mouth/Dental _____ 0 Pulmonary _____ 0 Neurology _____ 0 OB-GYN _____ 0 Ortho/Surg _____ 0 Pediatrics _____ 0 Psychiatric _____ 0 Toxicology _____ 0 Trauma _____ 0 Urology _____ general _____ abnormal test _____ lifestyle issues _____ more diagnoses _____		O activity / work-school _____ no restrictions _____ no strenuous activity _____ wt bearing as tolerated _____ no wt bearing _____ RT work _____ off work _____ RT school _____ off school _____ warnings _____ head _____ comps _____ infection _____ Tet given _____ sedative meds in ED _____ return if problems _____ follow-up _____ w/ your doctor _____ w/ specialist _____ return to ED _____ discharged home in _____	

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26/36

FIG. 27

<b>T-Chart</b>		<b>Abdominal Pain</b> time: _____ room: _____	
Mary		arrived: pvt vehicle EMS context: _____	
Historian: Mary Home		historian: patient EMS family limited	
Annotations		OHPI	
Chief complaint: abdominal pain _____ flank pa		started: just PTA today last night yesterday	
still present _____ gone _____ timing: _____		location: R chest-central-L chest	
quality "pain" _____		epig _____ LUQ _____	
sharp _____		RUQ upper LUQ _____	
stabbing _____		generalized _____	
cramping _____		R flank _____	
burning _____		R back _____	
dull _____		RQ _____ LLQ _____	
migrating _____		R pelvis _____ L pelvis _____	
... _____		suprapub _____	
well localized _____		R back _____	
diffuse _____		additional pain _____	
radiating to: _____		associated symptoms: _____	
nausea _____		vomiting _____	
loss of appetite _____		diarrhea _____	
severity of pain: _____		modifying factors: _____	
T-Chart		other	
Mary		OTHER HISTORY	
Historian: Mary Home		CVS-PESP	
Annotations		chest pain _____	
Chief complaint: abdominal pain _____ flank pa		palps _____	
started: just PTA today last night yesterday		dyspnea _____	
still present _____ gone _____ timing: _____		cough _____	
quality "pain" _____		foot swing _____	
sharp _____		calf pain _____	
stabbing _____		GI	
cramping _____		nausea _____	
burning _____		vomiting _____	
dull _____		NEURO/PSYCH	
migrating _____		minutes _____	
... _____		hours _____	
well localized _____		days _____	
diffuse _____		weeks _____	
radiating to: _____		months _____	
nausea _____		years _____	
loss of appetite _____		today since yesterday recently chronically	
severity of pain: _____		gone now -still present -improving -worsening	
modifying factors: _____		VOMITING	
T-Chart		mild moderate severe	
Mary		once twice several times numerous	
Historian: Mary Home		blood-tinged w/frank blood	
Annotations		dark coffee-grounds	
Chief complaint: abdominal pain _____ flank pa		billous faculent	
started: just PTA today last night yesterday		similar to previous symptoms	
still present _____ gone _____ timing: _____		1 2 3 4 5 -	
quality "pain" _____		for 6 7 8 9 0 1/2	
sharp _____		several	
stabbing _____		many	
cramping _____		occasionally	
burning _____		today since yesterday recently chronically	
dull _____		gone now -still present -improving -worsening	
migrating _____		minutes _____	
... _____		hours _____	
well localized _____		days _____	
diffuse _____		weeks _____	
radiating to: _____		months _____	
nausea _____		years _____	
loss of appetite _____		today since yesterday recently chronically	
severity of pain: _____		gone now -still present -improving -worsening	
modifying factors: _____		VOMITING	
T-Chart		mild moderate severe	
Mary		once twice several times numerous	
Historian: Mary Home		blood-tinged w/frank blood	
Annotations		dark coffee-grounds	
Chief complaint: abdominal pain _____ flank pa		billous faculent	
started: just PTA today last night yesterday		similar to previous symptoms	

**FIG. 28A**

ⓑ

**FIG. 28B**

Closure <input type="checkbox"/> <input checked="" type="checkbox"/>	<p><u>-rhonchi</u></p> <p><u>-wheezes</u></p> <p><u>-prolonged expirations</u></p>
---	--

---

<p><u>-warm, dry</u></p> <p><u>-no rash</u></p> <p>0 NEURO</p> <p><u>-oriented x</u></p> <p><u>-no motor deficit</u></p> <p><u>-no sensory deficit</u></p> <p><u>-reflexes nm</u></p>	<p><u>(skin rash)</u></p> <p><u>-poor skin turgor</u></p> <p><u>-altered mental status</u></p> <p><u>-CN deficit</u></p> <p><u>-weakness</u></p> <p><u>-sensory deficit</u></p> <p><u>-reflex exam:</u></p>
---	---

FIG. 29

**Clinical Report**  
Hospital Name - Emergency Department  
Street Address - 214-555-1212  
12-Apr-2001

---

Patient Name: Mary

**PHYSICAL EXAM**  
Eyes: Scleral icterus. Pale conjunctivae.  
ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.  
Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.  
Abdomen: Obese. Rebound tenderness. Guarding present.  
Skin: Cyanosis. Skin rash.  
Neuro: Oriented X 3. No motor deficit. No sensory deficit.

---

Physician Signature

**29/36**

[illegible]

FIG. 30

[illegible]

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FIG. 31

T-Chart
Jane
Home
Annotations
4 8
Notes
Clinical
History
Exam
Course
Dx/DI
Viewing
Report
Discharge
Prescription
Excuse
Printing
Clinical
Discharge
Closure
11

## Clinical Report

Hospital Name-

Emergency Department

Street Address - 214-555-1212

26-Jul-2001

Patient Name: Jane

### PAST HISTORY

Peptic ulcer, Gall stones, Bowel obstruction

### PHYSICAL EXAM

Eyes: Scleral icterus. Pale conjunctivae.

ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.

Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.

Abdomen: Obese. Rebound tenderness. Guarding present.

GU: Speculum and bimanual exam performed. Cervical lesion present.

Discharge present from the cervical os.

Skin: Cyanosis. Skin rash.

Neuro: Oriented X 3. No motor deficit. No sensory deficit.

Physician Signature

FIG. 32

**TSYS 25,410**  
Title: METHOD FOR ENTERING,  
RECORDING, DISTRIBUTING AND  
REPORTING DATA  
Inventor(s): Woodrow W. Gandy et al  
U.S. Serial # 09/927,972  
**31/36**

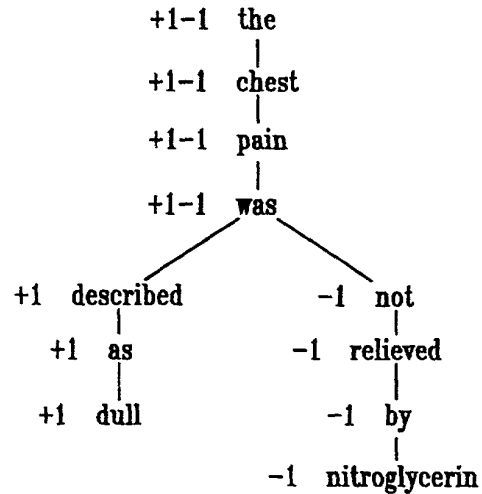
T-Chart		EKG / X-RAYS / STUDIES		PROCEDURE NOTES	
Jane	0 EKG_nml 0 CXR_NAD 0 V/Q scan_nml 0 Abdomen_NAD 0 IVP_NAD 0 Other X-rays_neg	0 CT Head_NAD 0 CT Chest_NAD 0 CT Abdomen_NAD 0 Abdominal Sono_NAD 0 Pelvic Sono_NAD 0 Other studies_neg	0 Intubation 0 Ventilator Management 0 Chest tube	0 Central Line 0 Thrombolytic Therapy	
Annotations			PROGRESS		
⌄			TIME: _ now stable unstable sx's gone much better better unchanged exam improved unchanged		
📝 Notes			[APPLY]		
Clinical	0 CBC nml except	0 Cardiac Enz nml except	0 PFTs Peak Flow 0 U/A	Evaluation after reassessment. Physical exam findings are unchanged.	
📋 History	WBC Hgb HCT Plat segs bands lymphs monos	CK CKMB myoglobin Troponin T Troponin I 0 Pulse Ox time FI02	cath clean nml except WBCs RBCs bacteria blood leuk est nitrite gluc ketones Bili protein HCG sHCG Quant uHCG	Evaluation after multiple exams. Physical exam findings are unchanged. The patient's symptoms are unchanged.	
📋 Dx/Di	0 COAG PT PTT INR	0 Chem CMP BMP ISTAT nml except Na K Cl HCO3 Glu #2 BUN Cr Tol Prol Albumin T.Bili SGOT Alk Phos Ca Mg PO4 Amylase Lipase	0 U/A	Evaluation after observation, results of tests back, analgesic and narcotic. Physical exam findings are improved. Symptoms much better.	
Viewing				0 general course 0 Resp / CVS 0 CPR 0 re-evaluation	
Report				consultation / review of records D/W Dr. _old records ordered D/W Dr. (#2) _old records reviewed tried - can't contact Dr. _records req-unavailable family consultation _further history sought	
Discharge				hospital admission or transfer admit _good condition transfer _stable observation status _	
Prescription					
Excuse					
Printing					
Clinical					
Discharge					
Closure					
📁					



FIG. 34

T-Chart	Clinical Report	
Jane	Hospital Name--	
Home	Emergency Department	
Annotations	Street Address - 214-555-1212	
Annotations	26-Jul-2001	
Notes	Patient Name: Jane	
Clinical	PAST HISTORY	
Clinical History	Peptic ulcer, Gall stones, Bowel obstruction	
Exam	PHYSICAL EXAM	
Course	Eyes: Scleral icterus. Pale conjunctivae.	
DrD1	ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.	
Viewing	Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.	
Report	Abdomen: Obese. Rebound tenderness. Guarding present.	
Discharge	GU: Speculum and bimanual exam performed. Cervical lesion present. Discharge present from the cervical os.	
Prescription	Skin: Cyanosis. Skin rash.	
Excuse	Neuro: Oriented X 3. No motor deficit. No sensory deficit.	
Printing	PROGRESS AND PROCEDURES	
Clinical	E.D. Course: Evaluation after reassessment. Physical exam findings unchanged.	
Discharge	Evaluation after multiple exams. Physical exam findings are unchanged. The patient's symptoms are unchanged.	
Closure	Evaluation after observation, results of tests back, analgesis and narcotic. Physical exam findings are improved. Symptoms much better.	
Closure	Physician Signature	

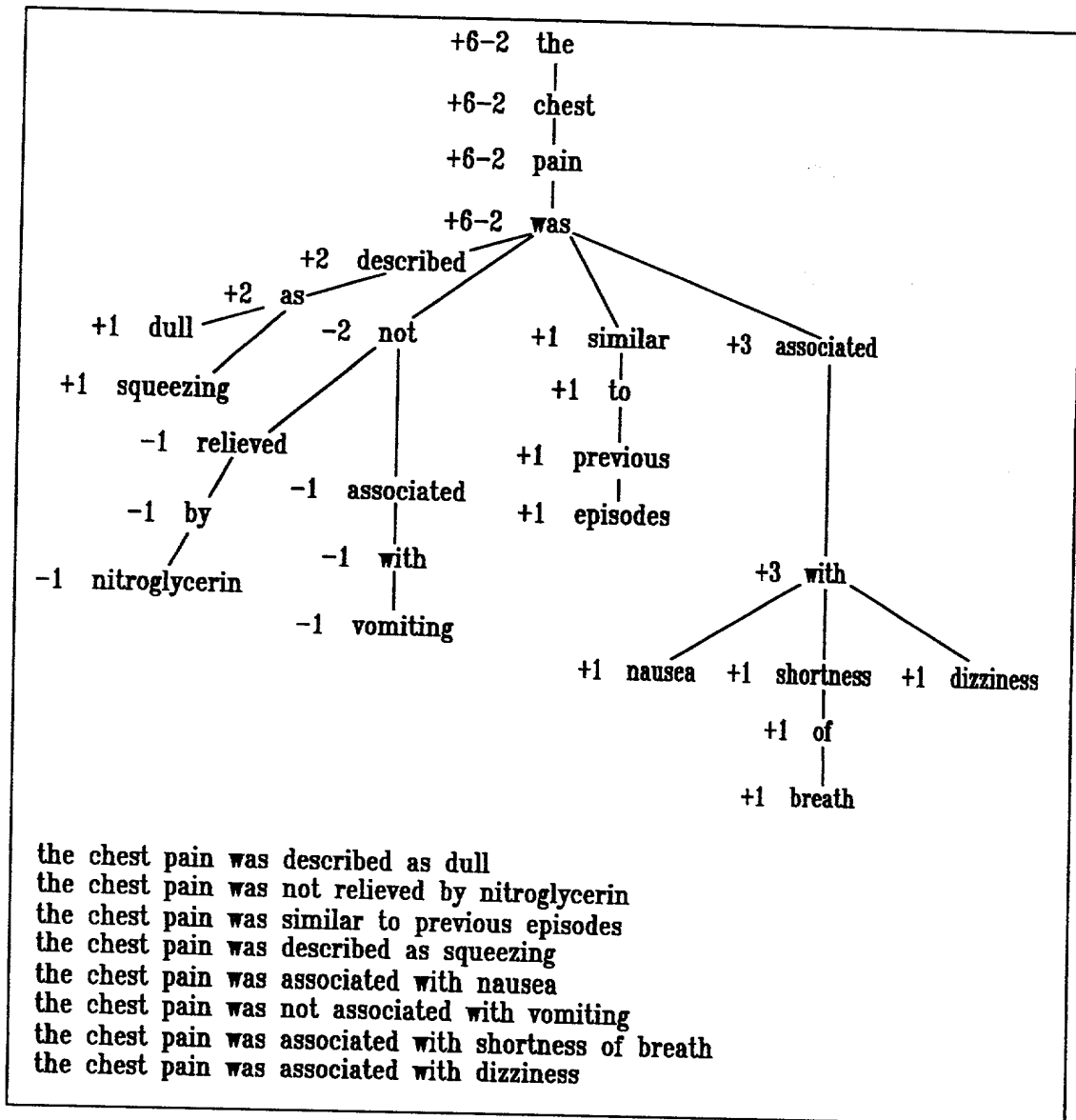
FIG. 35



the chest pain was described as dull  
the chest pain was not relieved by nitroglycerin

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FIG. 36



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FIG. 37

Test TSysTPRL

the patient has had a prior history of \*\* cancer of the stomach

the patient has had a prior history of \*\* cancer of the brain

the patient has had a prior history of \*\* diabetes

the patient has had a prior history of \*\* congestive heart failure

the patient has had a prior history of \*\* gout

the patient has had a prior history of \*\* ingrown toenails

the patient has had a prior history of \*\* alcohol abuse

the patient has had a prior history of \*\* scabies

Generate

Min Text

Space

Semicolon

Comma

Crunch

The patient has had a prior history of cancer of the stomach, cancer of the brain, diabetes, congestive heart failure, gout, ingrown toenails, alcohol abuse and scabies.